MILLIMAN WHITE PAPER

Law and Executive Order

A look at how President Trump's executive order on healthcare impacts the ACA's small group and individual markets

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"Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States,"[1] signed by President Trump on October 12, 2017, may be the most important shift in commercial healthcare policy since the passage of the Patient Protection and Affordable Care Act (ACA).

The order could have a significant effect on both the individual and small group health insurance markets. The extent of any impact on either market will vary depending on how the executive order is interpreted and implemented by administrative agencies, as well as whether those interpretations hold up to legal challenges. In this paper, we summarize the executive order and analyze key considerations and potential impacts for commercial health plans.

What it says

The executive order promotes three specific vehicles the Trump administration believes will provide lower-cost health insurance options to small employers and individuals:

1. Association health plans (AHPs)
2. Short-term limited duration insurance (STLDI)
3. Health reimbursement arrangements (HRAs)

The order seeks to expand access to associations by making it easier for small employers to form and join them based on common geography or industry. While the final legal status of current and newly formed AHPs is not entirely clear, the order suggests that AHPs will not be subject to state insurance regulations and the ACA's consumer protection provisions. This preemption could be accomplished by self-funding, so that the association health plan is regulated solely by ERISA. Regardless of funding status, the order suggests that AHPs should be treated as large groups.

The order further seeks to pare back restrictions imposed on STLDI by the Obama administration and to make this coverage more accessible to individuals. It seems likely the coverage periods for STLDI policies will be extended to allow for terms longer than the current three-month limit (potentially up to one year) and those individuals will be allowed to purchase an additional STLDI policy after the termination of their existing STLDI coverage. Because STLDI is exempt from most ACA requirements as an excepted benefit, this is consistent with the president's order on AHPs to provide another avenue for consumers to purchase coverage at a lower cost, albeit with fewer consumer protections.

Finally, the order seeks to expand usability of, and access to, HRAs. HRAs currently allow employers to help fund their employees' health plan cost-sharing obligations. The order particularly seeks to expand the ability of members to use HRA funds to also pay premiums, either for the group health plan or for non-group coverage, while also loosening employers' restrictions around offering HRAs to group members.

Association health plans

OVERVIEW

The language related to association health plans (AHPs) found in the executive order appears primarily directed at the small group market.[2] This is in spite of the fact that, relative to the individual ACA market, the ACA small group market has enjoyed significantly lower premium rate increases, has had carriers remain in the market, and has had a stable regulatory environment. However, the small group market is also not without its challenges, demonstrated by declining overall enrollment as employers struggle to find value in offering coverage.[3] Although the expansion of AHPs through the executive order is intended to improve pricing and availability of coverage for small employers, it also has the potential to create disruption in the ACA small group market. If AHPs are allowed to operate under a different set of rules than the ACA small group market (see Figure 1), a separate market will form

1 The full executive order may be found at **https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition** (retrieved October 12, 2017).

2 The executive order uses the words "small business" or "small employer" four times with no references to the individual market.

3 Source: 2014, 2015, and 2016 Supplemental Health Exhibits; 2014 and 2015 MLR Reports.

with potential advantages in risk selection. This favorable selection by AHPs will conversely mean negative selection for the ACA small group market and result in upward pressure on ACA-compliant small group premium rates.

EFFECT OF AHPS ON SMALL GROUP MARKET RISK POOL

Direct risk selection, such as explicitly declining coverage to small employers, has been prohibited by law in most states since the early 1990s, and was formally disallowed nationwide in the late 1990s.[4] Likewise, for small employers purchasing coverage in the ACA small group market, the ability of carriers to underwrite or rate groups based on health status has also been prohibited in all states since the passage of the ACA.[5] Given that the executive order cannot contravene existing laws, these prohibitions will continue under the executive order for the small group market. By contrast, small employers purchasing through an AHP could be governed by large group market rules.

The shaded entries in Figure 1 above highlight the key differences between the small group and large group market rules. These differing rules favor AHPs, particularly self-funded AHPs, in terms of their abilities to attract, segment, and rate for risk. This favorable risk selection will drive lower prices for AHPs and leave the ACA small group market with higher-cost groups. We discuss each of these in more detail below.

1. **Rating factors:** Under large group rules, AHPs would not be subject to ACA rating factor restrictions, which may allow them to offer lower premiums for younger, healthier groups. For example, large group rules could allow AHPs to use industry factors and an age curve wider than the ACA's 3:1 slope.
2. **Covered benefits and cost sharing:** AHPs would have greater flexibility to develop lean benefit packages compared to the ACA's essential health benefits (EHBs).[6] For example, AHPs may revert to pre-ACA small group benefits by excluding or limiting mental health benefits[7]

4 See, for example, Table 1 of **https://aspe.hhs.gov/report/impact-access-regulation-health-insurance-market-structure**, published October 20, 2000 (retrieved October 20, 2017). Guaranteed availability and renewability in the group market were required by the Health Insurance Portability and Accountability Act (HIPAA) and codified in 42 USC 300gg-11 starting in 1997. See **https://www.gpo.gov/fdsys/pkg/USCODE-1997-title42/pdf/USCODE-1997-title42-chap6A-subchapXXV-partA-subpart3.pdf** (retrieved October 25, 2017).

5 Per 42 USC 300gg(a)(1)(B), at **https://www.gpo.gov/fdsys/pkg/USCODE-2015-title42/pdf/USCODE-2015-title42-chap6A-subchapXXV-partA-subpart1-sec300gg.pdf** (retrieved October 25, 2017).

6 For more information on EHBs see: **http://www.milliman.com/uploadedFiles/insight/2017/essential-health-benefits.pdf**.

7 The Mental Health Parity and Addiction Equity Act does not require coverage of mental health and substance abuse (MHSA) services, though it does require that any limitations placed on any covered MHSA services be substantially no more restrictive than similar non-MHSA inpatient and outpatient services. Moreover, the ACA includes MHSA treatment as an EHB, so MHSA services receive the same protections as other EHBs.

FIGURE 1: RULES APPLYING TO POSSIBLE SMALL GROUP EMPLOYER INSURANCE OPTIONS AFTER EXECUTIVE ORDER (EXCLUDING GRANDFATHERED)

	CURRENTLY AVAILABLE				POTENTIAL ADDITIONAL OPTIONS WITH THE EXECUTIVE ORDER	
SUB-MARKET	ACA	TRANSITIONAL	SELF-FUNDED	AHP UNDER SG	AHP UNDER LG	AHP SELF-INSURED
Insurance type	Fully insured	Fully insured	Self-funded	Fully insured	Fully insured	Self-funded
Regulator	State/Feds	State	ERISA[a]	State/Feds	Situs State	ERISA[a]
Interstate sales allowed	No	NA	NA	Yes	Yes	Yes
Minimum loss ratio	80%	80%	NA	80%[b]	85%[b]	NA
Network adequacy	Yes	No	No	Yes	No	No
Guaranteed issue	Yes	NA	No	Yes	Yes	Yes
Guaranteed renewability	Yes	Yes[c]	No	Yes	Yes	Yes
Age rating limitations	Yes	No[d]	No	Yes	No[d]	No[d]
Industry rating factors[e]	No	Yes	Yes	No	Yes	Yes
Group-level health status rating	No	Yes	Yes	No	Possible	Yes
EHBs required	Yes	No	No	Yes	No	No
$0 preventative care required	Yes	Yes	Yes	Yes	Yes	Yes
State mandated benefits	Yes	Yes	No	Yes	Situs state	No
Mandated actuarial values	Yes	No	No	Yes	No	No
State premium taxes apply	Yes	Yes	No	Yes	Yes	No

NOTE: Shaded areas represent differences from the ACA that may affect rating.

a ERISA regulates benefit plan but states may still regulate any related stop loss.

b Regulation applies to insurer, not AHP.

c Dependent on state extension of transitional policy.

d Some states do impose limitations.

e Where allowed some states impose limits on industry and group size factors

and some or all prescription drug benefits. AHPs could also exclude EHBs such as wellness and maternity benefits to reduce costs, although both of these benefits tend to be popular with younger workers, and other EHBs may be necessary to keep in order to remain competitive for employee hiring and retention. When factoring in costs associated with these benefit exclusions, AHPs can offer leaner benefit plans with higher member cost sharing than the ACA-mandated minimum bronze plan.

3. **Administrative costs:** The large group fully insured market is subject to a higher minimum loss ratio than the small group market. This means administrative expenses will need to be lower than those inherent in the current small group market for insurers writing fully insured AHPs business to avoid paying refunds. AHPs could have lower administrative costs through efficiencies in distribution costs, lower acquisition costs, cross-product selling opportunities, and not being subject to state premium taxes under a self-funded scenario. Beyond these advantages, it may be difficult for AHPs to reduce their operating expenses. Depending on the total number of AHPs operating in a state or region, it is unlikely that any one AHP will have the scale necessary to drive significantly lower operating costs. Although lower administrative costs will allow AHPs to have lower premium rates than ACA plans, it is not expected to be the main driver of premium rate differential between AHPs and ACA plans.
4. **Experience rating:** The overall health status of AHP membership would be heavily influenced by the factors mentioned above: the ability to segment and rate for risk, reduced covered services, and leaner coverage of the benefits offered. Younger, healthier groups are more likely to buy leaner plans with fewer covered benefits, resulting in favorable selection and lower premium rates. Moreover, because large groups can be experience-rated, this favorable selection should directly translate to lower premium rates for AHPs as the plan does not need to share health status savings via the risk adjustment program.
5. **Flexibility:** The expansion of AHPs could make employers more willing to leave coverage currently classified as grandfathered or transitional. Many employers, particularly those with relatively favorable risk profiles, have kept their transitional or grandfathered plans. Healthier employers find the ACA market does not offer coverage at competitive prices because ACA plans cannot reflect health status in premium rates, while transitional and grandfathered plans can. Employers with transitional plans may be hesitant to enter the ACA market, because once in the ACA market an employer cannot go back and purchase a transitional or grandfathered plan that rewards it for an improvement in health status. Expansion of AHPs would create additional coverage options for these groups, allowing healthier groups currently with ACA plans to either self-insure or, when eligible, join AHPs, while less healthy groups with ACA plans remain in the ACA market.

As is usual with significant market realignments, the process of arriving at stable pricing for AHPs could be lengthy and possibly disruptive depending on the rules under which they would need to operate. There may be a period of aggressive pricing by AHPs that may or may not reflect actual costs, allowing time for an accumulation of experience data that ultimately leads to sound actuarial pricing. This process would produce not only a significant amount of member movement and disruption, but also a shakeout in the AHP market, leaving only the competitive and profitable carriers standing, and potentially a less competitive and less stable ACA small group marketplace.

EFFECT OF AHPS ON INDIVIDUAL MARKETS

The executive order does not appear to contemplate expanding associations to include individuals. However, the administration could modify existing rules to allow self-employed individuals with no employees to participate in a "group health plan" and hence in an AHP such that this participation does not undermine an AHP's "bona fide" status.

Assuming associations are able to enroll individuals, the ACA market morbidity would presumably worsen. It should be noted, however, that low-income individuals would likely stay in the ACA market because AHP premiums are unlikely to be lower than ACA premiums net of subsidies. Moreover, less healthy individuals would likely remain in the ACA market to maintain the higher levels of coverage and benefits than what they are likely to find with an AHP. Therefore, AHPs would be most attractive to individuals who are either not eligible for an ACA subsidy (that is, with income above 400% of the federal poverty level) or who receive a small subsidy and are relatively healthy—the very same members who may be sitting out of the ACA today.

Short-term, limited-duration insurance (STLDI)

OVERVIEW

The executive order points out "the [Obama administration] took steps to restrict access to [the STLDI] market by reducing the allowable coverage period from less than 12 months to less than three months and by preventing any extensions selected by the policyholder beyond three months of total coverage." Assuming the regulations promulgated in response to the executive order lengthen STLDI plan durations to 12 months, a possible consequence is that healthy, unsubsidized ACA individuals would cancel their current plans and purchase STLDI plans instead. Once these individuals develop chronic conditions they can reenter the ACA market during open enrollment to take advantage of its chronic-condition-friendly consumer protections.

EFFECT OF STLDI ON INDIVIDUAL MARKETS

Several factors might influence consumer decisions, including:

1. **Underwriting:** Typically, STLDI plans do not require rigorous medical underwriting because those expenses would be in addition to already high acquisition expenses. These are difficult to recover from short-duration contracts. Instead, because STLDI plans typically do not cover the cost of services related to preexisting conditions, the plans rely on rigorous reviews after claims are incurred to determine whether they are related to a pre-existing condition (post-claim underwriting). An issue faced by insureds is that sometimes they do not realize that they have what the insurer may consider a pre-existing condition.
2. **"Renewability" and preexisting conditions:** Even before the Obama administration's ban on extensions, STLDI plans were generally not renewable; however, STLDI enrollees often purchased another STLDI plan, extending their coverage.[8] This distinction is important because a new STLDI policy resets the preexisting conditions exclusion provision. In other words, conditions developed while enrolled under an STLDI policy are not covered during the following STLDI term. This contract provision is especially confusing to policyholders and leads to litigation risk for health plans.
3. **Covered benefits:** STLDI benefits do not need to cover all EHBs and can include benefit limits not allowed in comprehensive medical coverage, most typically a maternity coverage exclusion and limits on behavioral health and certain therapy services. However, STLDI plans sold today are otherwise typically designed to look like these permanent plans.
4. **Premium levels:** Due to underwriting, preexisting condition exclusions, age-rating flexibility, and fewer covered services, STLDI premiums are significantly lower than ACA individual plan premiums.
5. **Mandate penalty:** STLDI plans do not provide minimum essential coverage (MEC) and therefore trigger a penalty under the ACA. The 2018 mandate penalty (if it is not repealed and is actually enforced) is the greater of 2.5% of household income and $695 for an individual or $2,085 for a family of three or more, capped at the nationwide average cost of bronze coverage.

Individuals deciding whether to purchase a lower-priced STLDI plan should include the potential mandate penalty when comparing total cost against ACA plans. The table in Figure 2 provides a simplistic example of the STLDI purchase-making decision for 2018, assuming a federal poverty level (FPL) of $12,060 and an ACA monthly premium of $400.[9] Health plans considering offering STLDI options in response to the executive order should consider plan designs that target a premium savings from the ACA to STLDI greater than the mandate penalty (i.e., a STLDI premium lower than the calculated monthly break-even STLDI premium shown in Figure 2).

FIGURE 2: SAMPLE STLDI DECISION FOR AN INDIVIDUAL IN 2018

	400% FPL	500% FPL	600% FPL	1000% FPL
Annual Income	$48,240	$60,300	$72,360	$120,600
Mandate Penalty (2.5% of income)	$1,206	$1,507	$1,809	$3,015
Annual Individual ACA Premium	$4,800	$4,800	$4,800	$4,800
Break-even Premium for STLDI	$3,594	$3,293	$2,991	$1,785
Monthly Break-even STLDI Premium	$300	$274	$249	$149

A possible consequence of any expansion of STLDI availability is an increase in ACA morbidity as a result of the anticipated movement of healthy individuals from the ACA pool to the STLDI pool. The extent of that impact would depend on how aggressively health plans design, market, and sell STLDI plans to healthy individuals, as well as on how the federal government would enforce the individual mandate.[10] The target STLDI market includes the currently uninsured and healthy individual ACA enrollees who do not currently receive premium subsidies. Because the ACA has not been overly attractive to healthy, unsubsidized individuals, it remains to be seen whether the effect of this aspect of the executive order will be to decrease the uninsured level, or to attract current ACA enrollees, further increasing ACA morbidity and premiums.

Health reimbursement arrangements

Health reimbursement arrangements (HRAs) have long been a feature of employer coverage. Much like health savings account (HSAs), HRAs can be used to pay for eligible medical expenses. One key difference between an HSA and an HRA is that funds can only be deposited into an HRA by the employer and remain the property of the employer if unused, while funds deposited into an HSA immediately become the property of the insured. As a result, HRAs are only found in employer-sponsored coverage.

Prior to the ACA, employers could provide HRAs to individuals that could be used to purchase coverage in the individual market, which saved the employer from some of the administrative

8 Prior to the ACA rule limiting STLDI sales, most insurers allowed one extension, usually limited to the same duration length or term of their first policy. If the insured wanted a third or a different term, he or she would need to enroll through a different insurer.

9 $400 is based on the average 33-year-old 2018 premium rate across all FFE bronze plans.

10 The Internal Revenue Service (IRS) has indicated that it will reject 2017 tax returns that do not indicate MEC, a hardship exemption, or pay the mandate penalty. See **https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision** (retrieved October 25 2017).

hassles of operating a health plan. Upon the ACA's adoption, the U.S. Department of Health and Human Services (HHS) ruled that this was no longer possible because employees then had effective annual limits (equal to the amount of HRA funding) on the coverage provided by employers. While the 21st Century Cures Act created a limited exception, it only allowed small employers without a group health plan to offer HRAs to employees, and the amount of the HRA reduced any premium tax credit for which the individual was eligible. Other employers could still offer HRAs, but would only be able to do so as part of a group health plan (in which case the employee would have access to minimum essential coverage and would not need to purchase coverage in the individual market).

Expanding the pool of available uses for HRA funds would present another avenue of choice for employees, which is especially valuable given that funds generally expire at the end of the plan year. Allowing the purchase of non-group coverage would provide a greater benefit to those who find that the employer's group health plan is not to their personal tastes or needs, which could in turn lead to more satisfied employees. The expansion of HRAs could impact the individual market if employers with group rates based on health status design HRAs to steer less healthy group members into the individual market. If premiums for the rest of the group health plan are based only on the remaining healthier members, those premiums would decrease.

Summary/conclusion

The Trump administration is encouraging the expansion of AHPs, STLDI, and HRAs as ways to provide other choices to consumers in addition to plans offered in the ACA small group market and possibly in the individual market, though the exact opportunities and the impact to each market will depend on the final regulatory actions taken. While much is still uncertain, carriers should pay close attention to forthcoming details of precisely how the executive order will be carried out. Specifically, carriers should be prepared to:

- Evaluate the adverse effects of AHP selection against the ACA small group single risk pool and take appropriate actions.
- Depending on implementation details, evaluate the same impacts to individual portfolios but also include the impacts of STLDI.
- Evaluate strategic portfolio realignments to position for growth in new markets while hedging emerging risks in others.

Ultimately, carriers should continually evaluate how the government interprets and implements this executive order, as well as other potentially related regulatory items, such as the individual mandate enforcement and cost-sharing subsidy funding to be ready for the evolving health coverage landscape.

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